遠雄人壽 Farglory Life

Application for Group Insurance Claim

CLA003

Claim Adjuster Stamp

※For fast processing in claim adjustment, applicant should fill in every field of the form. For further information and the documents required, refer to the notes on p.2

I. Information on Insured

Proposer
(Name of School):

Name of Insured: ID No.:

_____Dept/Institute: _____ Year _____Class Student ID: _____
(Name of Department)

Date of Birth		Telephone		Cell Phone No.	

Mailing Address: ☐☐☐☐☐ county city / Village/township District / Village Li / Road Street / Section / Alley Lane / No. Floor

II. Items applied

Medical	☐Medical Benefits	☐Major burns Benefits
Death & disability	☐Death Benefits	☐Dismemberment Benefits
Others	☐Other	☐Documents for amount submitted bill in excess of medical benefit

III. Detail of event

Time Occurred: ☐am ☐pm Hour Minute

Cause: ☐Illness ☐Accident

Medical Identity: ☐NHI ☐Own expense

Treated at Hospital/clinic: _____(※The "diagnosis certificate" is required. Fill in the "Declaration of Consent for Inquiry and Authorization" on p.3)

※Fill in this field for accident.

Place of accident: ☐Home ☐Workplace ☐Others _____

Occupation and job content at the time of the accident:

Police report date:

Reporting to: _____ Police Station _____Sub-station

Officer name: _____Telephone: _____

Specify the cause of the accident and detail: (※ If there is police report or newspaper or news media reports, please provide related information or clippings)

IV. Method of payment

☐ T/T	Account title	Name of Bank	Branch name	Account number

☐ Check

Mail to ☐ Mailing address of the insured
☐ Other designated address: _____

※1. If more than 1 beneficiary has provided photocopies of their front cover of bank passbooks, the account information for remittance can be skipped.

※2. If there is no selection concerning the payment method or no information on the bank account for remittance, the account information cannot be identified, or there is no attachment of photocopies of passbook, the Company will issue a check for payment.

※3. For beneficiaries under the age of 20 who elect to cancel the non-endorsable and non-transferable requirement of checks, the beneficiary and the deputy agent shall submit an "application for change in status of check" and the ID certification documents. Upon the authentication of the ID of the beneficiary, the Company will process the request. If the amount of the check exceeds NTD50,000, the beneficiary and the deputy agent shall visit the office of the Company in person with the presentation of the original ID documents for application of the cancellation of the non-endorsable and non-transferable requirement for check payment.

Signature/seal of the proposer (school)

Proposer

President (Representative)

Declaration of consent:

1. The undersigned agrees to appoint the "messenger/insurance agent of insurance broker/service staff" as the authorized agent for processing the claim adjustment and related matters, and further agrees that the Company may deliver related documents/information on claim adjustment to the undersigned in the care of such party.
2. In case any of the fields in the "Declaration of Consent on Inquiries and Authorization", "Authorization for Viewing Information on Medical History of All Hospitals", and the "Application for Information from Insurer of National Health Insurance under National Health Insurance Administration Ministry of Health and Welfare" were left blank, the undersigned agrees to authorize Farglory Life to fill it and make appropriate choices.
3. The beneficiary/guardian has cautiously read and acknowledged the content of the "Obligations of Notice of the Performance of the Obligations by Life Insurance Industry in the Protection of Personal Information".
4. For the application for death insurance benefit, the undersigned (beneficiary) hereby agrees that Farglory Life may elect to conduct cross-reference between the aforementioned information and the information in the death announcement system for the accuracy of the content contained in the autopsy report (or death certificate) attached to the application for insurance benefit claim.

Signature of the insured/beneficiary:_____ID card number: _____
(The insured is the beneficiary of medical insurance benefits)

Signature of deputy Agent/guardian/auxiliary assistant: _____ID card number _____
(Required if the beneficiary is a minor or person under guardianship or the assistance from an auxiliary assistant)

Application date: (※ if left blank, the date of receiving by the Company shall be deemed the application date)

Farglory Life Group Insurance Department Received Stamp	**Stamp of processing staff:** **Receipt/processing record:**

Item for application		Documents required for application for insurance benefits
Medical benefits	Paid as spent	1. Application for Group Insurance Claim 2. Diagnosis report 3. Original receipts for medical treatment service and the itemized bill 4. Statement of consent on the collection, processing, and use of personal information contained in medical history, medical and health examination.
	Daily benefit	1. Application for Group Insurance Claim 2. Diagnosis report 3. Statement of consent on the collection, processing, and use of personal information contained in medical history, medical and health examination.
	Bone fracture benefit	1. Application for Group Insurance Claim 2. Diagnosis report 3. X-ray film 4. Statement of consent on the collection, processing, and use of personal information contained in medical history, medical and health examination.
Cancer benefit	Initial cancer insurance benefit	1. Application for n Group Insurance Claim 2. Declaration of Consent on Inquiries and Authorization 3. Diagnosis report 4. Related examination report or pathological section report 5. Statement of consent on the collection, processing, and use of personal information contained in medical history, medical and health examination.
	Cancer medical benefit	1. Application for Group Insurance Claim 2. Declaration of Consent on Inquiries and Authorization 3. Diagnosis report 4. Related examination report or pathological section report 5. Statement of consent on the collection, processing, and use of personal information contained in medical history, medical and health examination.
Critical illness		1. Application for Group Insurance Claim 2. Declaration of Consent on Inquiries and Authorization 3. Diagnosis report 4. Related examination report or pathological section report 5. Statement of consent on the collection, processing, and use of personal information contained in medical history, medical and health examination.
Dismemberment benefit		1. Application for Group Insurance Claim 2. Declaration of Consent on Inquiries and Authorization 3. Diagnosis report 4. Statement of consent on the collection, processing, and use of personal information contained in medical history, medical and health examination. ● Dismemberment caused by accident: document for proof of accident is required ● Amputation or defect: X-ray film
Death benefit		1. Application for Group Insurance Claim 2. Declaration of Consent on Inquiries and Authorization 3. Death certificate or related autopsy certificate 4. Deregistered household registration record 5. ID of beneficiary 6. School registration document (The "Official Seal and Processing Stamp" of the school is required. The personal seal of the processing staff shall also be affixed for proof of eligibility of the applicant). 7. Statement of Consent by legitimate successor (the form is available at the administration office) ● Death by accident: document for proof of injury by accident is required.

I. Important notice:

1. Please provide the aforementioned documents for relevant types of insurance benefits applications. If additional documentation is required, the processing staff will keep the applicant informed.
2. Documents issued by a foreign country shall be subject to notarization and authentication before being accepted as valid documents as required by law. Please visit the official website of Bureau of Consular Affairs of Ministry of Foreign Affairs (http://www.boca.gov.tw).
3. If the cause of death is under the status of "In Anatomy for Verification", provide the Anatomy Report" or the "Autopsy Report" with the cause of death specified.
4. Application for medical insurance benefit or disability claim due to accident under "bone fracture", please provide the X-ray film for differentiation of the severity of bone fracture (full fracture, partial fracture, or crack) and to determine the position of fracture.
5. In applying for death benefit or total disability caused by accident, please provide the "Certification document of injury by accident" (such as police investigation report) to speed up the processing of claim adjustment.
6. For facilitating the claim adjustment investigation, the processing staff may request for the supply of "Declaration of Consent on Inquiries and Authorization" exclusive for relevant agencies (hospitals). If the undersigned is the victim/the deputy agent of the beneficiary of the deceased/guardian/auxiliary assistant, please also provide the proof of relation (such as the photocopy of the household registration record and court ruling).
7. If the insured in the application for total disability is a mentally retarded or mentally impaired person the extent to which such person cannot express its intent or accept the expression of intent, or unable to identify the effect of the expression of intent, or lacks the aforementioned capacity, the ruling of the court on guardianship or requirement of auxiliary assistance is required.
8. For application of insurance claim related to "cancer" (such as critical illness, cancer medical treatment, death by cancer), provide the cancer pathological section report or related examination reports as evidence.
9. For the application for insurance benefits for Caesarean section due to medical reasons, medical history is not required at regional hospitals or hospitals at a higher level, but the photocopies or delivery record is required for gynecology and obstetrics clinics.
10. Identification document for the beneficiary refers to the certified true copy of the household registration record or the photocopy of the front side of ID card (if the beneficiary is a statutory successor, the certified true copy of the full household registration record in required further to the photocopy of the front side of the ID card is required and to fill in the "Declaration of Consent of the Successor" for the confirmation of the number of successors and the amount of payment).
11. If the beneficiary applies for total disability insurance benefit, the Company may conduct physical examination on the insured, and review the medical records of the insured at the consent of the beneficiary where necessary. The Company shall bear all the expense incurred thereof but will not delay the payment of insurance benefit as provide by the insurance contract.
12. If the insurance claim is made by a third party, the power of attorney is required.
13. According to the National Health Insurance Act and the Regulations Governing the Deduction of National Health Insurance and Payment for Supplementary Insurance:
    - 13.1 If the responsible insured fails to pay interest in arrears within 15 days and such interest is defined as interest income under the Income Tax Act, this will be subject to the deduction of supplementary insurance premium.
    - 13.2 For a lump sum payment of interest in arrears amounting to NT$20,000~NT$10,000,000, the Company shall deduct supplementary insurance premium at the premium rate as required.
14. If the insurance benefit for the death of the insured featured coverage at critical illness, coverage at old age, coverage with lump sum premium payment, short-term coverage, large amount coverage, intensive coverage, or insurance benefit falls below or relevant with the amount of premium paid, the taxation authorities will apply the Tax Code for levy of applicable tax if there is an allegation of evading estate tax.

◆Contact: the Insurance Office of the school (e.g., Health Care Division or Student Affairs Office)

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Farglory Life Insurance (hereinafter referred to as "the Company") hereby inform you of the following pursuant to Article 8-1 and Article 9-1 of the Personal Information Protection Act (hereinafter referred to as "PIPA"), you are asked to read the contents thoroughly:

I. The purpose of information collection:

(I) Personal insurance (001), court judgment (056), gathering and use by financial service industry as required by law or ad dictated by financial supervision (059), handling financial disputes (060), financial supervision, management and examination (061), insurance supervision (066), contracts, contract like or other legally related affairs (069), emergency rescue of nationals in foreign countries (085), consumer, customer management and service (090), other business operation conforming to the purpose of business registration or the articles of association (181), and other specific purpose lawfully related.

(II) For purpose of reason permitted by law.

II. Types of personal information for collection:

All necessary personal information classified as the business transactions and contracts, documented authorization of agent, and application documents between you and the Company.

III. The sources of personal information:

(I) The proposer (II) The deputy agent, auxiliary assistant of the party concerned (III) Hospitals and clinics

(IV) Joint marketing, sharing of customer information, and cooperation in promotion with a third party, or the third party commissioned by the Company for handling internal business.

IV. The duration, targets, regions, and means of using personal information:

(I) Duration: as required for the operation and as required by law for retention.

(II) Targets: The Company (and branches), The Life Insurance Association of the R.O.C., The Non-Life Insurance Association of the R.O.C., Taiwan Insurance Institute, Taiwan Insurance Guaranty Fund, Financial Ombudsman Institution, Joint Credit Information Center, National Credit Card Center, Taiwan National Clearing House, Financial Information Service Co., Ltd., outsourced contractors, reinsurers with reinsurance business to the Company, institutions entitled to conduct investigation or financial supervisory authorities.

(III) Region: the regions where the aforementioned targets are located. (IV) Means: any means in compliance with applicable laws.

V. According to Article III of the Personal Information Protection Act, you are entitled to handle your personal information accessed by the Company in the following means:

(I) The right of demand from the Company: 1. Inquiry, viewing and for copies of your personal information; 2. For providing supplementary information or making correction to the information; 3. For stopping further collection, processing or using of information or deletion of information.

(II) Means of exercising rights: at any service center of the Company or call the toll free customer service hotline (0800-083-083).

VI. Your declining to provide personal information may affect your rights and privileges specified as follows:

Should you fail to provide your personal information as required, the Company may have to postpone or be unable to proceed to necessary review and processing, and, the Company may not be able to underwrite your insurance policy, delay, or be unable to provide related service or payment.

Statement of Consent in the Collection, Processing, and Use of Personal Information Contained in Medical History, Medical and Health Examination

To: Farglory Life Insurance

Pursuant to Article 177-1 of the Insurance Act and the Personal Information Protection Act and the regulations governing related authorization, the Company shall collect, process, and use your personal information contained in medical history, medical and health examination. Further to the business transactions, documented authorization of agent and application documents between you and the Company, the collection, processing, and use of your personal information in medical history, medical and health examination shall be aiming at and within the scope of customer service, solicitation, underwriting, contract protection, reinsurance, claim, complaints and settlement of disputes related to your personal insurance, and the internal control and audit of the Company in compliance with applicable laws. Should you not consent to the collection, processing, and use of your personal information by the Company, we may not be able to provide you the application for personal insurance and related processing.

The Undersigned (who is the insured), understands the aforementioned statement and hereby agrees that your Company may collect, process, and use of my personal information containing in the medical history, medical and health examination within the scope as permitted by applicable laws, and convey the aforementioned information to reinsurers of the Company for reinsurance underwriting or claim adjustment. The Undersigned hereby duly declares that this statement constituted the expression of intent of the Undersigned under free will.

Signature of the Undersigned (the insured): _____

Signature of Deputy Agent/Guardian/Auxiliary Assistant: _____(Relation to the insured: _____)

(For the Undersigned who is a minor or under guardianship or declared for support under an auxiliary assistant)

Date:_____

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Declaration of Consent on Inquires and Authorization

To: Hospital (clinic), police station (sub-station, traffic patrol), fire service (emergency rescue) institution, district public prosecutor office, Life Insurance Association, Non-Life Insurance Association, insurer, or any other related entities or persons

In the matter of the application for insurance benefit payment form **Farglory Life Insurance Co., Ltd. (hereinafter referred to as "Farglory Life")**, the Undersigned hereby acts on behalf of and in the name of the □Insured □Parent of the insured □ Spouse of the insured □Child of the insured □Successor of the insured(relation:) (Name: _____; Date of birth: _____; ID card number: _____) to request you, the hospital (clinic), police station (sub-station, traffic patrol), fire service (emergency rescue) institution, district public prosecutor office, Life Insurance Association, Non-Life Insurance Association, insurer, or any other related entities or persons, to assist the personnel dispatched by Farglory Life to sort and search (including the operation of the online and telephone voice registration system for inquiry within the scope of the aforementioned purpose, or make registration in the name of and on behalf of the insured in supporting the operation requirement of the hospital and clinic), consult, retrieve and view, hand copy, and/or photocopy of the medical history of the Undersigned in all departments (name of disease: _____), information provided for insurance underwriting, or any information related to the accident entitled for insurance claim for this instance (including files in hard copy and softcopy)covering the period of 5 years in retrospect from the date the contract is caused into full force: _____, to the date this declaration statement is signed and executed, as reference and evidence. In witness thereof, the Undersigned hereby causes this instrument to be duly executed as.

If any of the above field is left blank, the Undersigned agrees that the personnel of Farglory Life may act on behalf of and in the name of the Undersigned to fill in the space and further agrees that Farglory Life may use photocopies of this instrument which shall carry the same effect as of the original specimen of this instrument and shall act accordingly.

In case the hospital (clinic), police station (sub-station, traffic patrol), fire service (emergency rescue) institution, district public prosecutor office, Life Insurance Association, Non-Life Insurance Association, insurer, or any other related entities require specific format of this instrument, the Undersigned shall comply accordingly by providing related documents.

The undersigned: **(authorized signature and seal)** ID No.:

Deputy Agent: **(authorized signature and seal)** ID No.:

(If the Undersigned is a minor, please fill in the deputy agent with the photocopies of the front and backsides of the ID card or the certified true copy of the household registration record for proof of relation)

Telephone: Mobile phone:

Mailing Address:

Date:

Note: Please enclose this instrument with the **authorized signature and seal affixed** to your application for insurance claim, and the Company will quickly process your application. This instrument without **your authorized signature and seal** may cause delay in processing if inquiry of medical history is necessary. (Please be noted that some hospitals, such as National Taiwan University Hospital, Veterans General Hospital in different regions, hospitals administered by Ministry of Health and Welfare in all regions, and Tzu Chi Hospital in different regions, may require specific format of the document. We will let you know of further assistance from you if supplementary document for consent is required).